FOR OHF USE

LL1

ZUUZ STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2002)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 LCS 4/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 00078	380		II. CERTIF	ICATION BY AUTHORIZED FACILITY OFFICER
Facility Name: COUNTRY HEALTH Address: R R 1 BOX 14 Number County: CHAMPAIGN Telephone Number: (217) 568-7362 IDPA ID Number: 376064916	Gifford City Fax # ()	61701 Zip Code	and certi are true, applicab is based	examined the contents of the accompanying report to the Illinois, for the period from 01/01/2002 to 12/31/2002 The period from
Date of Initial License for Current Owners: Type of Ownership: xx VOLUNTARY,NON-PROFIT	01/01/70 PROPRIETARY	7 governmental	Officer or Administrator (of Provider	Signed)
xx Charitable Corp. Trust	Individual Partnership	State County		Signed)
IRS Exemption Code	Corporation "Sub-S" Corp. Limited Liability Co. Trust Other	Other	Preparer a	Print Name CRAIG L. ATER and Title) Senior Vice President Finance Firm Name & Address) (Date) Heritge Enterprises
In the event there are further questions about the Name: CRAIG L. ATER	nis report, please contact: Telephone Number: <u>(</u>)			Telephone) (309)823-7135 Fax # () MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Faci	ility Name & ID Numb	oer COUNTRY I	HEALTH				# 0007880 Report Period Beginning: 01/01/2002 Ending: 12/31/2002
	III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/o	certification level(s) of	f care; enter number	of beds/bed days,			(Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	change in licensed b	eds			
				_			E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
							NONE
	Beds at				Licensed		
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census?
	Report Period	Level of	Care	Report Period	Report Period		
	•			•	•		G. Do pages 3 & 4 include expenses for services or
1	79	Skilled (SNI	F)	79	1	investments not directly related to patient care?	
2			atric (SNF/PED)		28,835	2	YES NO XX
3	10	Intermediat	e (ICF)	10	3,650	3	
4		Intermediat	e/DD			4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5	0	Sheltered C	are (SC)	0	0	5	YES NO XX
6		ICF/DD 16	or Less			6	
							I. On what date did you start providing long term care at this location?
7	89	TOTALS		89	32,485	7	Date started <u>01/01/70</u>
							J. Was the facility purchased or leased after January 1, 1978?
	B. Census-For	the entire report per					YES Date NO NO xx
	1	2	3	4	5		
	Level of Care		by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		Public Aid					YES xx NO If YES, enter number
		Recipient	Private Pay	Other	Total		of beds certified and days of care provided 2,195
8	SNF	13,445	10,758	2,195	26,398	8	
9	SNF/PED			0		9	Medicare Intermediary Mutual of Omaha
	ICF					10	
	ICF/DD					11	IV. ACCOUNTING BASIS
	SC	0	0	0		12	MODIFIED
13	DD 16 OR LESS					13	ACCRUAL XX CASH* CASH*
14	TOTALS	13,445	10,758	2,195	26,398	14	Is your fiscal year identical to your tax year? YES XX NO
	C Paraont Oa	cupancy. (Column 5,	ling 14 divided by to	tal licancad			Tax Year: Fiscal Year:
		n line 7, column 4.)	81.26%	tai neenseu			* All facilities other than governmental must report on the accrual basis.
	sea anys or		01.2370	_			dian go to innerval mass report on the next and substitution

STATE OF ILLI	INOIS				P
#	0007880	Report Period Beginning:	01/01/2002	Ending:	

	Facility Name & ID Number	COUNTRY HE	ALTH	;	STATE OF ILI	LINOIS 0007880	Report Period	Beginning:	01/01/2002	Ending:	Page 3 12/31/2002	
	V. COST CENTER EXPENSES (through				llar)							-
			osts Per Genera	- 0		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHE	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	177,374	10,418		187,792		187,792		187,792			1
2	Food Purchase		117,712		117,712		117,712		117,712			2
3	Housekeeping	76,927	15,390		92,317		92,317		92,317			3
4	Laundry	47,635	9,422		57,057		57,057		57,057			4
5	Heat and Other Utilities			77,570	77,570		77,570		77,570			5
6	Maintenance	55,932	37,336	21,522	114,790		114,790		114,790			6
7	Other (specify):*											7
8	TOTAL General Services	357,868	190,278	99,092	647,238		647,238		647,238			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,030,136	66,911	156,094	1,253,141		1,253,141		1,253,141			10
10a	Therapy		66,662	131,895	198,557	(74,990)	123,567		123,567			10a
11	Activities	63,805	5,207		69,012		69,012		69,012			11
12	Social Services	36,558	14	1,683	38,255		38,255		38,255			12
13	Nurse Aide Training	878	536	,	1,414		1,414		1,414			13
14	Program Transportation				ŕ		ŕ		,			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,131,377	139,330	295,672	1,566,379	(74,990)	1,491,389		1,491,389			16
	C. General Administration	, í		ĺ								
17	Administrative	54,529			54,529		54,529		54,529			17
18	Directors Fees											18
19	Professional Services			135,476	135,476		135,476	(8,672)	126,804			19
20	Dues, Fees, Subscriptions & Promotions			89,530	89,530	(48,728)	40,802	(26,590)	14,212			20
21	Clerical & General Office Expenses	131,734	10,822	11,913	154,469	, , , ,	154,469	, , ,	154,469			21
22	Employee Benefits & Payroll Taxes			330,982	330,982		330,982		330,982			22
23	Inservice Training & Education			1,999	1,999		1,999		1,999			23
24	Travel and Seminar			11,934	11,934		11,934	(9,935)	1,999			24
25	Other Admin. Staff Transportation			, ,	, ,		, -	())	,		1	25
26	Insurance-Prop.Liab.Malpractice			86,990	86,990		86,990		86,990		1	26
27	Other (specify):*			11,758	11,758		11,758	(11,758)				27
28	TOTAL General Administration	186,263	10,822	680,582	877,667	(48,728)	828,939	(56,955)	771,984			28
	TOTAL Operating Expense	<i>′</i>		<i>′</i>	<i>'</i>		,	(/ /	<i>'</i>			
29	(sum of lines 8, 16 & 28) *Attach a schedule if more than one typ	1,675,508	340,430	1,075,346	3,091,284	(123,718)	2,967,566	(56,955)	2,910,611			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Page 4 12/31/2002 **Report Period Beginning:** 01/01/2002 Ending:

V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			101,216	101,216		101,216		101,216			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,237	3,237		3,237	(3,237)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,482	15,482		15,482	(494)	14,988			35
36	Other (specify):*											36
37	TOTAL Ownership			119,935	119,935		119,935	(3,731)	116,204			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					74,990	74,990		74,990			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					48,728	48,728		48,728			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					123,718	123,718		123,718			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,675,508	340,430	1,195,281	3,211,219		3,211,219	(60,686)	3,150,533			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

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Ending:

0007880

Report Period Beginning:

01/01/2002

12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	I Amount	2 Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(494)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(3,237)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(194)	20		17
18	Fines and Penalties	(3,250)	27		18
19	Entertainment	(9,935)	24		19
20	Contributions		27		20
	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(8,672)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,508)	27		24
25	Fund Raising, Advertising and Promotional	(26,396)	20		25
	Income Taxes and Illinois Personal				
26					26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
	Other-Attach Schedule Real estate taxes		33		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (60,686)		\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2
		Amount	Reference
31	Non-Paid Workers-Attach Schedule*	\$	31
32	Donated Goods-Attach Schedule*		32
	Amortization of Organization &		
33	Pre-Operating Expense		33
	Adjustments for Related Organization		
34	Costs (Schedule VII)		34
	Other- Attach Schedule		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$	36
	(sum of SUBTOTALS		
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (60,686)	37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

(See instructions)

(56	e instructions.)	1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS

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COUNTRY HEALTH

Report Period Beginning:
Ending:

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Sch. V Line

	NON-ALLOWABLE EXPENSES		Amount	Reference	
1		\$	0	0	1
2			0	0	2
3			0	0	3
4			0	0	4
5			(494)	35	5
6			0	34	6
7			0		7
8			0		8
9			0	30	9
10				32	10
11		-+-	0	32	11
12			0		12
13			0	2	13
14			0	32	14
15			0	33	15
16			0	24	16
17			(194)	20	17
18			(3,250)	27	18
19				24	19
20			0	27	20
21			0		21
22			(8,672)	19	22
23			0		23
24			(8,508)	27	24
25			(26,396)	20	25
26			0	0	26
27			0	0	27
28			0	0	28
29			0	0	29
30			0	0	30
31			0	0	31
_		-	0	0	_
32					32
33			0	33	33
34					34
35					35
36					36
37					37
38					38
39					39
40			-		40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48	Tatal		(47.54.1)		48
49	Total		(47,514)		49

STATE OF ILLINOIS

Summary A # 0007880 Report Period Beginning: 01/01/2002 Ending: 12/31/2002 Facility Name & ID Number COUNTRY HEALTH

	SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61												
													SUMMARY
	Operating Expenses	PAGES	PAGE	TOTALS									
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6Н	6 I	(to Sch V, col.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0 1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0 2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0 3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0 4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0 5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0 6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0 8
	B. Health Care and Programs												
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0 9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0 10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0 10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0 11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0 12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0 13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0 14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0 16
	C. General Administration												
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0 17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0 18
19	Professional Services	(8,672)	0	0	0	0	0	0	0	0	0	0	(8,672) 19
20	Fees, Subscriptions & Promotions	(26,590)	0	0	0	0	0	0	0	0	0	0	(26,590) 20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0 21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0 22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0 23
24	Travel and Seminar	(9,935)	0	0	0	0	0	0	0	0	0	0	(9,935) 24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0 25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0 26
27	Other (specify):*	(11,758)	0	0	0	0	0	0	0	0	0	0	(11,758) 27
28	TOTAL General Administration	(56,955)	0	0	0	0	0	0	0	0	0	0	(56,955) 28
	TOTAL Operating Expense												
29	(sum of lines 8,16 & 28)	(56,955)	0	0	0	0	0	0	0	0	0	0	(56,955) 29

STATE OF ILLINOIS

COUNTRY HEALTH

0007880 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Facility Name & ID Number

													SUMMARY	
	Capital Expense	PAGES	PAGE	TOTALS										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col	.7)
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,237)	0	0	0	0	0	0	0	0	0	0	(3,237)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(494)	0	0	0	0	0	0	0	0	0	0	(494)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,731)	0	0	0	0	0	0	0	0	0	0	(3,731)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST							•				•		
45	(sum of lines 29, 37 & 44)	(60,686)	0	0	0	0	0	0	0	0	0	0	(60,686)	45

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Report Period Beginning:

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01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Atta	ch an additional schedule if necessary.
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A. Litter below the number of ALL o								
1		2		3				
OWNERS		RELATED NURSING HOMI		OTHER REL	ATED BUSINESS	S ENTITII	ES	
Name	Ownership %	Name	City	Nam	ie	City		Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
			-			Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V	10a	Adjustment for Related Organiza	tion	GreenTree Therapy	100.00%			2
3	V								3
4	V	19	Adjustment for Related Organiza	tion	Heritage Enterprises, Inc.	100.00%			4
- 5	V								5
6	V	10a	Adjustment for Related Organiza	tion	GreenTree Pharmacy	100.00%			6
7	V								7
8	V								8
9	V								9
10	V								10
11	V		<u> </u>					•	11
12	V								12
13	V		_					•	13
14	Total			\$			\$	\$ *	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS	
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39

0 \$ *

STATE OF ILLINOIS								
Facility Name & ID Number	COUNTRY HEALTH	#	0007880	Report Period Beginning:	01/01/2002	Ending:	12/31/2002	
management fees, purchase	s report which are a result of transactio of supplies, and so forth.	ns with related organizations? This includes ren YES NO ations must be fully itemized in accordance with						

the instructions for determining costs as specified for this form. 3 Cost Per General Ledger 5 Cost to Related Organization 6 7 8 Difference: Percent **Operating Cost** Adjustments for Schedule V Line Item Name of Related Organization of Related **Related Organization** Amount of Ownership Organization Costs (7 minus 4) Heritage Enterprises, Inc. 15 100.00% \$ 15 16 16 17 17 18 18 19 V 19 20 20 21 V 21 22 22 V 23 23 V 24 25 26 27 24 25 26 27 28 29 V V V V 28 V 29 V 30 V 30 31 V 31 32 33 34 35 V 32 33 34 35 36 37 V V V v 36 V 37 38 38

39 Total

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

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Facility Name & ID Number COUNTRY HEALTH	#	0007880	Report Period Beginning:	01/01/2002	Ending:	12/31/2002	
VII. RELATED PARTIES (continued) B. Are any costs included in this report which are a result of transactions with related organizations? This in management fees, purchase of supplies, and so forth. YES NO	ıcludes ren	t,					
If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accord	dance with						

the instructions for determining costs as specified for this form.

1		3 Cost Per General Le		5 Cost to Related Organization	6	7	8 Difference:
					Percent	Operating Cost	Adjustments for
Schedule	V L	ne Item	Amount	Name of Related Organization	of	of Related	Related Organization
					Ownership	Organization	Costs (7 minus 4)
15 V	V		S	Heritage Enterprises, Inc.	100.00%		\$ 15
	V						16
17 \	V						17
18 V	V						18
19 V	V						19
20 V	V						20
21 V	V						21
22	V						22
23	V						23
	V						24
20	V						25
	V						26
	V						27
20	V						28
27	V						29
50	V						30
	V						31
02	V						32
	V						33
	V						34
	V						35
50	V						36
57	V						37
38 V	V						38
39 Total	ıl		\$			\$ 0	\$ * 39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS Page 7

Facility Name & ID Number COUNTRY HEALTH # 0007880 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Hou	ırs Per Work				1
					Compensation		oted to this	Compensati	on Included	Schedule V.	1
					Received	Facility and	l % of Total	in Costs	for this	Line &	1
				Ownership	From Other	Work	Week	Reporting Period**		Column	1
	Name	Title	Function	Interest	Nursing Homes*	Hours Percent		Description	Amount	Reference	
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.

ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS Page	e 8	8
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STATE OF ILLINOIS												
Facility Name & ID Number	COUNTRY HEALTH	#	0007880	Report Period Beginning:	01/01/2002	Ending:	2/31/2002					
VIII. ALLOCATION OF INDIRECT COSTS												
A. Are there any costs includ or parent organization co	Name of Relate Street Address City / State / Zi Phone Number	p Code	()									
B. Show the allocation of cos	Fax Number		()									

	1	2	3	4	5		6	7	8	9	
	Schedule V		Unit of Allocation		Number of		Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being		Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among		Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1					g	\$		\$		\$	1
2				•							2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11						1					11
12						1					12 13
13 14						1					13
15						+					15
16											16
17						+					17
18						++					18
19											19
20											20
21											20
22											22
23											22
24											24
25	TOTALS					\$		\$		\$	25

5	TATE OF	ILLINOIS				Page 8A	
,,	0007000	D 4 D 1 D	01/01/2002	T2 - 3*	2/21/2002		

Facility Name & ID Number	COUNTRY HEALTH	#	0007880	Report Period Beginning:	01/01/2002	Ending:	2/31/2002	
VIII. ALLOCATION OF INDIRE	ECT COSTS							
				Name of Relate	d Organization			
A. Are there any costs include	d in this report which were derived from allocations of central	offic	ce	Street Address				
or parent organization cost	s? (See instructions.) YES NO			City / State / Zi	p Code			
				Phone Number		()		
B. Show the allocation of costs	below. If necessary, please attach worksheets.			Fax Number		()		

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	1101010100	1000	Square recey	Total Clints		S	\$	Cints	\$	1
2						*	*		-	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13 14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

		SIMIL	F ILLINOIS		Page 9
Facility Name & ID Number	COUNTRY HEALTH	# 0007880	Report Period Reginning	01/01/2002 Ending:	12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	l	2	3	4	5	6	7	8	9	10	
				Monthly				Maturity	Interest	Reporting Period	
	Name of Lender	Related**	Purpose of Loan	Payment	Date of	Amou	ınt of Note	Date	Rate	Interest	
	Name of Lender	YES NO		Required	Note	Original	Balance	Date	(4 Digits)	Expense	
	A. Directly Facility Related	1ES NO		Requireu	Note	Original	Datatice		(4 Digits)	Expense	
		-									
4	Long-Term			1	ı	lo.	Φ.	l	ı	Φ.	
1						\$	\$			\$	1
2										<u> </u>	2
3										<u> </u>	3
4										ļ	4
5										<u> </u>	5
	Working Capital										
6	Gifford State Bank	XX	Working Capital			100,000				3,237	6
7											7
8										j	8
9	TOTAL Facility Related					\$ 100,000	\$			\$ 3,237	9
	B. Non-Facility Related*	1			J			_			
10	Interest Income									(3,237)	10
11											11
12											12
13											13
13											10
14	TOTAL Non-Facility Related					c	e ·			\$ (3,237)	14
17	101712 Ton-Facility Related	1				Ψ.	Ψ	-		(3,237)	17
1						100000					
15	TOTALS (line 9+line14)					\$ 100,000	\$			\$	15

¹⁶⁾ Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line #

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
0007880 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

Facility Name & ID Number COUNTRY HEALTH

IX INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continuation)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)
B. Real Estate Taxes

b. Real Estate Taxes					
	<i>Important</i> , please see the next worksheet	,, "RE_Tax". The real	estate tax statement and		
1. Real Estate Tax accrual used on 2001 report.	bill must accompany the cost report.			\$	1
2. Real Estate Taxes paid during the year: (Indicate	the tax year to which this payment applies. If payment cov	ers more than one year, de	etail below.)	s	2
3. Under or (over) accrual (line 2 minus line 1).				s	3
4. Real Estate Tax accrual used for 2002 report. (De	etail and explain your calculation of this accrual on the lin	es below.)		s	4
**	h has NOT been included in professional fees or other gen opies of invoices to support the cost and a co			\$	5
6. Subtract a refund of real estate taxes. You must of classified as a real estate tax cost plus one-half of TOTAL REFUND \$ For	* **	eal estate tax appeal	board's decision.)	\$	6
7. Real Estate Tax expense reported on Schedule V,	line 33. This should be a combination of lines 3 thru 6.			s	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1997 8		FOR OHF USE ONLY		
	1998 9 1999 10	13	FROM R. E. TAX STATEMENT F	OR 2001 \$	13
	2000 11 2001 12	14	PLUS APPEAL COST FROM LIN	E5 \$	14
		15	LESS REFUND FROM LINE 6	\$	15

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME COUNTR	RY HEALTH		COUNTY	CHAMPAIGN
FAC	ILITY IDPH LICENSE NUM	BER 0007880			
CON	TACT PERSON REGARDIN	G THIS REPORT Craig Ater	r		
TELI	EPHONE (309)823-7135		FAX#: ()	
A.	Summary of Real Estate Ta	ax Cost			
	Enter the tax index number a cost that applies to the operat home property which is vaca	and real estate tax assessed for 2 tion of the nursing home in Col nt, rented to other organization of include cost for any period of	lumn D. Real estat is, or used for purpo	e tax applicable to oses other than lon	any portion of the nursing
	(A)	(B)		(C)	(D)
1. 2. 3. 4. 5. 6. 7. 8. 9.				Total Tax \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	\$ \$
			TOTALS	\$	\$
B.	Real Estate Tax Cost Alloc	ations			= -
	Does any portion of the tax bused for nursing home service	oill apply to more than one nurs	sing home, vacant p	property, or proper	ty which is not directly
		a & a schedule which shows the cost must be allocated to the n			
С	Toy Bills				

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which

is normally paid during 2002.

STA	TE	OF	пт	INC	MC

Year Acquired

Cost

27,031

27,031

Page 11 Facility Name & ID Number COUNTRY HEALTH 0007880 Report Period Beginning: 01/01/2002 Ending: 12/31/2002 X. BUILDING AND GENERAL INFORMATION: 33,800 **B.** General Construction Type: Brick/Wood **Number of Stories** Square Feet: Exterior Frame (c) Rent from Completely Unrelated Does the Operating Entity? xx (a) Own the Facility (b) Rent from a Related Organization. Organization. (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.) xx (a) Own the Equipment (c) Rent equipment from Completely Does the Operating Entity? (b) Rent equipment from a Related Organization. Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.) List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable). YES NO Does this cost report reflect any organization or pre-operating costs which are being amortized? XX If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.) XI. OWNERSHIP COSTS: 2 3

Square Feet

Use

Land

3 TOTALS

A. Land.

Facility Name & ID Number COUNTRY HEALTH

0007880

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. 2 Year FOR OHF USE ONLY Year **Current Book** Life Straight Line Accumulated Beds* Acquired Constructed Cost Depreciation in Years Depreciation Adjustments Depreciation 744,720 1963 4 5 6 7 Improvement Type* 9 1976 Improvements 10 1977 Improvements 9 10 10,703 15,361 11 1978 Improvements 1977 25,766 11 12 1979 Improvements 1978 6,618 12 13 1980 Improvements 1980 30,846 13 14 1981 Improvements 18,567 14 1981 15 1982 Improvements 1982 4,662 15 28,833 16 1983 Improvements 1983 16 6,700 33,953 23,775 40,603 17 1984 Improvements 1984 17 18 1985 Improvements 19 1986 Improvements 18 19 20 1987 Improvements 20 21 1988 Improvements 163,565 21 22 1989 Improvements 1989 50,581 22 23 23 1990 Improvements 111,695 1990 24 24 1991 Improvements 1991 36,516 25 1992 Improvements 1992 26,816 25 26 1993 Improvements 1993 21,383 26 27 1994 Improvements 12,384 27 5,450 6,349 28 1995 Improvements 28 29 NURSE CALL SYSTEM 29 30 DINNING ROOM EXPANSION 10,109 30 31 Dinning Room Remodel 1997 6,121 31 32 32 33 33 34 C/O Allocation 34 35 Book Depreciation 56,737 56,737 1,164,783 35 36 36

See Page 12A, Line 70 for total

^{*}Total beds on this schedule must agree with page 2.

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

70 TOTAL (lines 4 thru 69)

0007880 Report Period Beginn

Report Period Beginning: 01/01/2002 Ending: Page 12A 12/31/2002

56,737

1,164,783

70

XI. OWNERSHIP COSTS (continued) B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. **Current Book** Year Life Straight Line Accumulated Depreciation Improvement Type** Constructed Cost Depreciation in Years Adjustments Depreciation 37 Dinning Room Remodel 1998 212,044 37 38 Resident Room Remodel 1998 63,596 38 39 Generator Regulator 1998 2,706 39 1998 1,088 40 40 Chiller/Air Conditioner 41 Threshold Improvement 1998 1,028 41 42 Garbage Disposal 42 1,170 43 Wanderguard 1998 2,132 43 44 Landscaping 44 1998 1,271 45 45 Gas Line 1998 1,445 46 46 47 Lobby Remodel-- Materials /Labor 1999 15,320 47 48 Concrete Border 1999 1,750 1,468 48 49 49 Landscapping 1999 50 Soffit & Fascia Replacement 1999 7,839 50 51 Dinning Room Project 1999 74,106 51 52 Resident Room Remodel 1999 21,649 52 53 54 Bathroom remodel -- labor and materials 2000 9,750 54 55 55 Smoke Detectors 2000 2,248 56 Room Remodel -- labor and materials 2000 4,030 56 57 57 Exhaust Fan 1,047 58 58 Hallway Flooring 2000 10,189 1,350 59 Bathroom Flooring 59 60 Drapes -- Lobby 1,361 60 61 2001 62 Ceramic Tile Shower 698 62 63 Hot Water Pump 2001 2,586 63 2001 2,208 64 64 Carpeting and Installation 65 Wander Guard 65 2001 1,270 2001 66 66 Light Fixtures and Door 2,777 1,311 67 Flooring 2001 67 68 69

1,891,513

56,737

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number COUNTRY HEALTH
XI. OWNERSHIP COSTS (continued)

0007880 Report Period Beginning:

Period Beginning: 01/01/2002 Ending:

Page 12B 12/31/2002

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. Year **Current Book** Life Straight Line Accumulated Improvement Type** Constructed Cost Depreciation in Years Depreciation Depreciation Adjustments 1 Totals from Page 12A, Carried Forward 1,891,513 56,737 56,737 1,164,783 1 2 3 Furnace 2002 2,262 3 2002 4,045 4 4 Boiler 5 Resident Room Remodel--Paint, flooring, drapes 2002 5,229 5 2002 2002 6 Dry Pendent 7 Door Alarm System 477 7 2002 8 8 Smoke Detection System 2,990 2002 9 9 Courtyard Improvements 25,600 10 A/C Laundry Room 2002 10 771 11 Signage 12 Sprinkler 13 2002 1,336 11 12 13 14 2002 1,190 14 15 15 16 17 16 17 18 18 19 19 20 21 20 21 22 22 23 24 25 23 24 25 26 26 27 27 28 28 29 30 30 31 31 32 32 34 TOTAL (lines 1 thru 33) 1,936,101 56,737 56,737 1,164,783 34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

STATE	OF I	LLIN	OIS

Page 13 Facility Name & ID Number COUNTRY HEALTH 0007880 **Report Period Beginning:** 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	ı î	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 606,915	\$ 44,479	\$ 44,479	\$		\$ 526,467	71
72	Current Year Purchases	38,148						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 645,063	\$ 44,479	\$ 44,479	\$		\$ 526,467	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76		1983 Chevy Van	1983	\$ 18,305	\$	\$	\$		\$	76
77		1985 Ford	1992	6,000						77
78		1996 DODGE VAN	1996	25,500						78
79										79
80	TOTALS			\$ 49,805	\$	\$	\$		\$	80

E. Summary of Care-Related Assets		2		_	
		Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,658,000	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 101,216	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,216	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84	1
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,691,250	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

STATE OF ILLINOIS

Faci	lity Name & I	D Number	COUNTRY HEALT	Н		# 0007880		Report	Period Beg	ınnıng:	01/01/2002	Ending:	12/31/200
XII.	1. Name of 2. Does the	and Fixed Equipn Party Holding Le	nent (See instructions. ease: real estate taxes in add		unt shown below o	n line 7, column 45	NO						
		1	2	3	4	5		6					
		Year	Number	Date of	Rental	Total Y	ears T	otal Years					
		Constructed	of Beds	Lease	Amount	of Lea	se Ren	ewal Option*					
	Original										ates of current		ment:
3	Building:			\$					3	Beginning			
4	Additions								4	Ending			
5									5				
6									6	11. Rent to be		years under t	he current
7	TOTAL			\$					7	rental agre	ement:		
	This amo by the le 9. Option to B. Equipmer 15. Is Mova	ount was calculate ongth of the lease b Buy: nt-Excluding Tran ble equipment re	YES nsportation and Fixed included in building the total sportation and Fixed included in building the equipment: \$	amount to be amed to be a meaning to be a meanin	ortized s:	YES pager, compute (Attach a s		ling the break	down of m	Fiscal Year 12. 13. 14. ovable equipmer	/2003 /2004 /2005	Annual Ross	
	C. Vehicle R	ental (See instruc	ctions.)										
	1		2		3	4							
			Model Year		hly Lease	Rental E							
15	Use	:	and Make	Pa	yment	for this	Period	1.7			s an option to l		
17 18				2		2		17 18			ovide complete	e details on at	tached
19				-		+		19		schedule	•		
20			_			+		20		** This ame	ount plus any a	mortization o	of lease
	TOTAL			•		e		21			must agree wit		
21	IUIAL			3		3		41		expense	must agree wit	n page 4, nne	J4.

		STATE OF ILLINOIS				Page 15
Facility Name & ID Number	COUNTRY HEALTH	#	0007880	Report Period Beginning:	01/01/2002 Ending:	12/31/2003

III. EXPENSES RELATING TO NURSE AIDE TRAINI	NG PROGRAMS (S	See instructions.)			report 2 crow Beginning. 02/02/2002 Enting. 12/02/20
A. TYPE OF TRAINING PROGRAM (If aides are tra	ained in another fac	ility program, attach a	schedule listing t	he facility name, ac	dress and cost per aide trained in that facility.)
1. HAVE YOU TRAINED AIDES	YES	2. CLASSROOM	PORTION:		3. CLINICAL PORTION:
DURING THIS REPORT PERIOD?	NO	IN-HOUSE PE	ROGRAM		IN-HOUSE PROGRAM
TEMOD.		n (noese ii	to Giu i i i		II HOUSE I ROOM IN
70H H N N N N N N N N N N N N N N N N N N		IN OTHER FA	ACILITY		IN OTHER FACILITY
If "yes", please complete the remainder of this schedule. If "no", provide an		COMMUNITY	COLLEGE		HOURS PER AIDE
explanation as to why this training was not necessary.		HOURS PER	AIDE		
B. EXPENSES	ALLOC	EATION OF COSTS	(d) 3	4	C. CONTRACTUAL INCOME In the box below record the amount of income your facility received training aides from other facilities.
		Facility			
4 0 0 0 0 0	Drop-ou	ts Completed	Contract	Total	\$
1 Community College Tuition	\$	536	\$	\$	D. NUMBER OF AIDES TRAINED
2 Books and Supplies 3 Classroom Wages (a)		878			378 D. NUMBER OF AIDES TRAINED
4 Clinical Wages (b)		070		- 0	COMPLETED
5 In-House Trainer Wages (c)					1. From this facility
6 Transportation					2. From other facilities (f)
7 Contractual Payments					DROP-OUTS
8 Nurse Aide Competency Tests					1. From this facility
9 TOTALS	\$	\$ 1,414	\$	\$ 1,4	2. From other facilities (f)
10 SUM OF line 9, col. 1 and 2 (e)	\$ 1,41	4	•		TOTAL TRAINED

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	(STEELIE SERVICES (Entitle Cost)	1	2	3	4	5	6	7	8	
		Schedule V	Stafi	f	Outsid	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other th	han consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	\$		\$ 52,430	\$		\$ 52,430	1
	Licensed Speech and Language									
2	Development Therapist	10a/3	hrs			8,177			8,177	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			60,923	2,037		62,960	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy	39/3	prescrpts				64,625		64,625	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): x-ray	39/3				10,365			10,365	13
14	TOTAL			\$		\$ 131,895	\$ 66,662		\$ 198,557	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

0007880 Report Period Beginning: As of 12/31/2002 (last day of reporting year)

XV. BALANCE SHEET - Unrestricted Operating Fund.

This report must be completed even if financial statements are attached.

1 2 After

		$\frac{1}{0}$	perating	2 After Consolidation*	
	A. Current Assets		per aring	Consolidation	
1	Cash on Hand and in Banks	S	189,319	S	1
2	Cash-Patient Deposits	-	7,795	Ψ	2
	Accounts & Short-Term Notes Receivable-		.,		_
3	Patients (less allowance		517,371		3
4	Supply Inventory (priced at)				4
5	Short-Term Investments				5
6	Prepaid Insurance		31,155		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)		(25,863)		8
9	Other(specify):		, ,		9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	719,777	\$	10
	B. Long-Term Assets			•	
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		27,031		13
14	Buildings, at Historical Cost		1,948,159		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		682,810		16
17	Accumulated Depreciation (book methods)		(1,691,250)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):		·		22
23	Other(specify): Deferred Tax Asset		·		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	966,750	\$	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	1,686,527	\$	25

		1		2 After	1
		O	perating	Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	179,514	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		7,795		28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		142,884		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		18,137		31
32	Accrued Real Estate Taxes(Sch.IX-B)				32
33	Accrued Interest Payable				33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	Security Deposits		25,661		36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	373,991	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$		\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	373,991	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	1,312,536	\$	47
	TOTAL LIABILITIES AND EQUITY				
48	(sum of lines 46 and 47)	\$	1,686,527	\$	48

01/01/2002

Page 17

12/31/2002

Ending:

^{*(}See instructions.)

0007880

Report Period Beginning: 01/01/2002

Page 18 Ending: 12/31/2002

			1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1,247,165	1
2	Restatements (describe):			2
3	Audit Adjustment		(7,428)	3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	1,239,737	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		72,799	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	72,799	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22			<u> </u>	22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	1,312,536	24

^{*} This must agree with page 17, line 47.

Ending:

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1				

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 3,258,478	1
2	Discounts and Allowances for all Levels	(503,009)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,755,469	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	360,415	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 360,415	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	3,449	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	124,422	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	952	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 128,823	23
	D. Non-Operating Revenue		
24	Contributions	36,057	24
25	Interest and Other Investment Income***	3,254	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 39,311	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,284,018	30

			2	
	Expenses		Amount	
	A. Operating Expenses			
31	General Services		647,238	31
32	Health Care		1,566,379	32
33	General Administration		877,667	33
	B. Capital Expense			
34	Ownership		119,935	34
	C. Ancillary Expense			
35	Special Cost Centers			35
36	Provider Participation Fee			36
	D. Other Expenses (specify):			
37	Loss from Non-Nursing property			37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	3,211,219	40
41	Income before Income Taxes (line 30 minus line 40)**		72,799	41
42	Income Taxes			42
43	NET INCOME OD LOSS FOR THE VEAR (line 41 minus line 42)	e.	72 700	12
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	Þ	72,799	43

*	This must	t agree with	page 4,	line 45,	column 4.
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**	Does this agree with	taxable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation

See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number COUNTRY HEALTH

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	2,044	2,132	\$ 46,337	\$ 21.73	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	7,738	8,332	147,506	17.70	3
4	Licensed Practical Nurses	8,838	9,669	139,446	14.42	4
5	Nurse Aides & Orderlies	52,398	57,400	621,336	10.82	5
6	Nurse Aide Trainees	100	100	878	8.78	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,089	5,625	75,511	13.42	8
9	Activity Director					9
10	Activity Assistants	7,543	8,267	63,805	7.72	10
11	Social Service Workers	3,344	3,697	36,558	9.89	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,688	20,100	177,374	8.82	15
16	Dishwashers					16
17	Maintenance Workers	3,719	4,178	55,932	13.39	17
18	Housekeepers	8,307	9,501	76,927	8.10	18
19	Laundry	5,208	5,844	47,635	8.15	19
20	Administrator	2,080	2,080	54,529	26.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,559	10,153	131,734	12.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,655	147,078	\$ 1,675,508 *	\$ 11.39	34

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		6,000		36
37	Medical Records Consultant		1,400		37
38	Nurse Consultant				38
39	Pharmacist Consultant		0		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,683		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 9,083		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		s 30,784		50
51	Licensed Practical Nurses		32,106		51
52	Nurse Aides		89,243		52
53	TOTAL (lines 50 - 52)		s 152,133		53
53	TOTAL (lines 50 - 52)		s 152,133		

^{**} See instructions.

STATE OF ILLINOIS		Page 21

Facility Name & ID Number C XIX. SUPPORT SCHEDULES	OUNTRY HEAL	ТН			#_ 000	07880	Repo	rt Period Beg	inning: 0	/01/2002 End	ing:	12/31/2002
A. Administrative Salaries		Ownershi	n		D. Employee Benefits and	Payroll Tayor			F Dues Fees	Subscriptions and Prom	otions	
Name	Function	%	h	Amount		ription		Amount		escription	onons	Amount
Pam Britt	Administrator	0	\$	54,529	Workers' Compensation I		•	57,200	IDPH License		•	400
and Britt	Administrator		- Ψ_	34,327	Unemployment Compensation 1		Ψ	6,169		Employee Recruitment	_ "-	7,291
					FICA Taxes	tton insurance	_	128,176		Worker Background Che	ck -	1,271
					Employee Health Insuran	ce	_	111,630		checks performed 50		569
-			-		Employee Meals		_		Central Office		=′ -	0
	-		-		Illinois Municipal Retiren	nent Fund (IMRF)*		•	Promotional A			23,197
 -			_		Employee Hepatitis Vaccir	· /	-	0	Public Relatio			3,199
ΓΟΤΑL (agree to Schedule V, line	17, col. 1)	-	-		Employee Benefits -		_	27,807	Dues and Sub	scriptions		5,814
(List each licensed administrator se	eparately.)		\$	54,529	Employee Benefits - centra	l office		0	License and F	ees		332
B. Administrative - Other												
								,	Less: Public	Relations Expense		(3,199
Description				Amount				,	Non-al	owable advertising		(194
			\$						Yellow	page advertising		(23,197
			_		TOTAL (C. I.	1 17		220.002		OTAT (14010
			_		TOTAL (agree to Schedu	le V,	\$ =	330,982	1	OTAL (agree to Sch. V,	\$_	14,212
TOTAL (15 1 2				line 22, col.8)	G B.11			66111	line 20, col. 8)		
TOTAL (agree to Schedule V, line			\$_		E. Schedule of Non-Cash	•			G. Schedule o	f Travel and Seminar**		
(Attach a copy of any management	service agreement	t)			to Owners or Employee	es				•		
C. Professional Services	m.				.	T. //			μ	escription		Amount
Vendor/Payee	Type		s	Amount	Description	Line #	e.	Amount	O-4 -6 54-4-7	P1	•	
Heritage Enterprises Sulaski & Webb	Management Fe	ees	. »_	118,242 5,900			» <u> —</u>		Out-of-State	i ravei	_ ³-	
Principal Financial	401K		-	1,600								
Theresa Rear	Sign Language		-	812			_	 -	In-State Trav	ol.		
Illinois State	Employee Surve	337	-	250			_		III-State ITav	CI		7,431
minois state	Employee Surve	<u>-J</u>	-	230			_					8
			-	-			_					
			-				_		Seminar Exp	ense		4,495
			-				_		Non Allowable			(9,935
Various	Legal		-	8,672			_		Central Office			0
Legal Fees (Adjusted to zero)			_	0			_					
			_	0			_		Entertainmer		(
TOTAL (agree to Schedule V, line	19, column 3)		_		TOTAL		\$			(agree to Sch. V,		
()												

Report Period Beginning: 01/01/2002

Ending:

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		s		\$	s	\$	s	\$	\$	\$	s	s

Facility	S y Name & ID Number COUNTRY HEALTH	TATE OF ILLI # 0007		Report Period Beginning:	01/01/2002	Ending:	Page 23 12/31/2002
XX. G	ENERAL INFORMATION:			•			
				supplies and services which are of the Public Aid, in addition to the daily			
(2)	Are there any dues to nursing home associations included on the cost report? <u>yes</u> If YES, give association name and amount. <u>Illinois Healthcare Association</u>		•	ction of Schedule V? yes	_		
(3)	Did the nursing home make political contributions or payments to a political action organization? no If YES, have these costs been properly adjusted out of the cost report? yes	the patie is a port	ent census l tion of the b	ouilding used for any function other isted on page 2, Section B? no ouilding used for rental, a pharmacy xplains how all related costs were a	, day care, etc.)	For example If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?	(15) Indicate on Scherelated of	edule V.		assified to employ meal income be the amount. \$	een offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? yes 7 years	(16) Travel a		ortation ncluded for out-of-state travel?	no		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $\frac{5,000}{100}$ Line $\frac{10}{100}$	If YE b. Do yo	ES, attach a	complete explanation. Eparate contract with the Department	nt to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.	c. What d. Have	t percent of e vehicle usa	this reporting period. \$ all travel expense relates to transponge logs been maintained? yes		_	? 100
(8)	Are you presently operating under a sale and leaseback arrangement? no If YES, give effective date of lease.	times	s when not i	stored at the nursing home during the nuse? yes commuting or other personal use of			
(9)	Are you presently operating under a sublease agreement? YES xx NO	out of	of the cost re		•		no
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO no If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over.	Indic , trans	icate the a sportation	mount of income earned from during this reporting period.	providing such \$	h 	_
		(17) Has an a Firm Na		performed by an independent certification of the laski & Webb	ed public accour		Yes tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 48,728 This amount is to be recorded on line 42 of Schedule V.		ort require	that a copy of this audit be included No If no, please explain.	Not complet	port. Has thi	is copy
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.	out of S	Schedule V?		C	,	
		perform	ned been att	re in excess of \$2500, have legal in ached to this cost report? d a summary of services for all arch		-	ices

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	CASE IN BANK PAYROLL ACCOUNTS SECRECABLE (CT)(C) MINOR AND RECEIVABLE	100	NO.
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